2014 RETIREE GROUP HEALTH PLAN ELECTION FORM

*For **Retirees Under Age 65***

Name: _____ **Emp. ID:** _____ **Date of Retirement:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Phone:** _____ **E-Mail Address:** _____

MEDICAL COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates for:	AvMed POS	AvMed High Opt HMO	AvMed Low Opt HMO
Retiree Only	☐ $ 1,052.74	☐ $ 432.10	☐ $ 406.96
Retiree & Spouse/ Domestic Partner Under 65	☐ $ 2,039.94	☐ $ 975.50	☐ $ 919.01
Retiree & Child(ren)	☐ $ 1,971.83	☐ $ 897.89	☐ $ 845.87
Retiree & Spouse/Domestic Partner Under 65 plus Child(ren)	☐ $ 2,468.52	☐ $ 1,210.75	☐ $ 1,140.71

Retiree Under 65 & Spouse/DP Medicare Eligible	AvMed POS	AvMed HMO HO
Retiree under 65 & Spouse/ Domestic Partner over 65 and/or Medicare Eligible - High Opt Plan	☐ $1,598.61	☐ $977.97
Retiree under 65 & Spouse/ Domestic Partner over 65 and/or Medicare Eligible - No RX Plan		☐ $669.37

DENTAL COVERAGE ☐ SELECT ☐ DECLINE

If yes, please select (√) one of the following options:

Monthly Rates for:	Delta Dental Plan		MetLife* DHMO (safeguard)		Humana* - Oral Health Services	
	Standard	Enriched	Standard	Enriched	Standard	Enriched
Retiree Only	☐ $ 31.22	☐ $ 40.87	☐ $ 8.70	☐ $ 12.67	☐ $ 8.00	☐ $ 14.82
Retiree & one dependent	☐ $ 61.76	☐ $ 80.81	☐ $ 14.38	☐ $ 21.00	☐ $ 13.23	☐ $ 24.57
Retiree & dependents	☐ $ 99.55	☐ $130.30	☐ $ 22.01	☐ $ 33.38	☐ $ 20.22	☐ $ 39.02

** Metlife DHMO and Humana OHS plans are not available outside Miami-Dade, Broward & Palm Beach Counties*

If medical and/or dental coverage for dependent(s) is selected, please provide the information below.

Name	Relationship**	SSN	DOB	Sex M/F	Indicate Coverage Selected
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental

****SP**- Spouse, **CH**-Child, **DP**-Domestic Partner, **DPCH**- Child of Domestic Partner

LIFE INSURANCE COVERAGE ☐ SELECT ☐ DECLINE

The value of the Miami-Dade County Retiree Group Life Insurance Policy is **one-time your base annual salary** at the time of retirement. The 2014 rate is **17 cents per thousand** dollars per month.

_____ I am aware that it is my responsibility to read and understand the contents of the Retiree Insurance Benefits Handbook available at http://www.miamidade.gov/humanresources/retirees.asp.

Signature _____ **Date** _____

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FRS IPDAF: _____ **Needed** _____ **Not Needed** **Conv. Letter: Yes** _____ **No** _____

Basic Life Conv. Amount $ _____ **Optional Life Conv. Amount $** _____

Please sign, date, and mail or fax this form to:
Miami-Dade County
Human Resources - Benefits Administration
111 NW 1st Street, Suite 2340
Miami, FL 33128-1979
Fax: 305-375-1633 or 305-375-1368